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FILE COPY

June 19, 2006

Patricia Aitchison, Administrator
Rose Haven
5023 E Powerline
Nampa, ID 83687

Dear Ms. Aitchison:

On June 6, 2006, a complaint investigation survey was conducted at Rose Haven. The survey was conducted by Patrick Hendrickson, R.N. and Frutoso Gonzalez, RN. This report outlines the findings of our investigation.

Complaint # ID00001461

Allegation #1: A resident was not assisted with medications when he returned to the facility after the caregiver had finished the medication assistance.

Findings: Based on record review, interview and review of a closed record it could not be determined the identified resident did not receive assistance with his medications.

Review of the identified closed record on June 6, 2006 revealed medication administration records (MAR) dated April 1, 2006 trough May 30, 2006 that documented the resident had not missed or refused medications from April through May 2006.

Review of the facility's admission discharge log on June 6, 2006 documented the identified resident was discharged on June 1, 2006.

On June 6, 2006 at 2:00 p.m., a caregiver who assisted the identified resident with his medications stated the resident was always assisted with his medications.

On June 6, 2006 at 2:10 p.m., the administrator said she was not aware of any instance where residents were not assisted with medications.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 6, 2006.

Allegation #2: Medications, including controlled substances, were not being disposed of properly. The facility did not have two people witness and sign for the disposal of medications.

Findings: Based on interview and record review it was determined medications, including controlled substances, were being disposed of properly. The facility did have two employees witness and sign for the disposal of medications.

Review of the facility's medication destruction log on June 6, 2006 documented medications were flushed down the toilet and two employees had witness and sign for the disposal of the medications.

On June 6, 2006 at 1:48 p.m., a caregiver who assisted with medications stated that it was the facility's policy to have two people witnessed and signed for the disposal of medications and she follows this policy when she needs to dispose of medications.

On June 6, 2006 at 2:00 p.m., the administrator said that it was the facility's policy to have two people witness and sign for the disposal of medications.

Conclusion: Unsubstantiated.

Allegation #3: Residents were not being assisted with activity's of daily living (ADL's). For example, resident undergarment Depends were not being changed at night, and a resident did not have her hair washed for several weeks.

Findings: Based on interview it was determined

On June 6, 2006 at 1:58 p.m., a random resident stated he was assisted with all of his activities of daily living (ADL's) and had no complaints about his care.

On June 6, 2006 at 2:00 p.m., a second resident stated the assisted her with ADL's if she needed. She said she did not require "much help."

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 6, 2006.

Allegation #4: Menus are not being followed and substitutions are not being documented. For example, the caller said she was instructed to serve ice water instead of milk, as milk was just for "special occasions."

Findings: Based on observations, interview and record review it was determined menus were being followed and substitutions were being documented. Additionally milk was being offered to residents with each meal.

Review of the facility's April and May 2006 menus on June 6, 2006 documented substitutions were written on the menus. The menus also documented that milk was offered to residents with each meal.

On June 6, 2006 at 12:58 p.m., it was observed the facility had 3 gallons of milk in the refrigerator.

On June 6, 2006 at 1:48 p.m., a caregiver stated residents were offered milk with each meal and substitutions to meals were documented on the menu.

On June 6, 2006 at 1:58 p.m., a random resident stated he was offered milk with each meal and could have milk at any time.

On June 6, 2006 at 2:00 p.m., the administrator said that she has had no complaints from residents they were refused milk.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 6, 2006.

Allegation #5: Snacks were not being served at the facility, and when residents request snacks they were denied them.

Findings: Based on observations, interview and record review it was determined that snacks were being served at the facility.

On June 6, 2006 at 12:58 p.m., it was observed the facility had a large fresh bowl of fruit, crackers and other snacks available for residents.

On June 6, 2006 at 1:48 p.m., a caregiver stated residents were offered snacks.

On June 6, 2006 at 1:58 p.m., a random resident stated he is offered snacks often and if he is hungry he can have a snack at any time. It was further observed at that time the resident had 2 packs of crackers in his room.

On June 6, 2006 at 2:00 p.m., the administrator said that she had no complaints from resident's that they were not offered snacks.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 6, 2006.

Allegation #6: The facility did not do background check on new hires.

Findings: Based on interview and record review it was determined the facility does background checks.

Review of a employees record on June 6, 2006 documented the employee was hired on May 10, 2006 and their employment was terminated on May 24, 2006.

Review of a second employees record documented the employee was hired on May 20, 2006 and their employment was terminated on May 29, 2006.

Each employee did have a background check paperwork filled.

On June 6, 2006 at 2:00 p.m., the administrator said that she had had each employee #1 and #2 fill out their background paperwork and was awaiting for them to go to the Meridian police department to be fingerprinted. She said employee #1 and #2's employment was terminated before they went to the Meridian police department to be fingerprinted.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 6, 2006.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Patrick Henderson, R.N.
Team Leader

Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Virginia Loper, R.N., Supervisor, Residential Community Care Program